		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033647

Facility Name: Snyder Village

Address: 1200 East Partridge (Number) Metamora (City) 61548 (Zip Code)

County: Woodford

Telephone Number: (309) 367-4300 **Fax #** (309) 367-2235

IDPA ID Number: 371194111001

Date of Initial License for Current Owners: 6/30/88

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Mike Kaplan **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,430	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	105	TOTALS	105	38,430	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,099	22,582	2,073	32,754	8
9	SNF/PED					9
10	ICF	391	3,583		3,974	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,490	26,165	2,073	36,728	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.57%

D. How many bed-hold days during this year were paid by Public Aid?
94 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 6/30/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 6/30/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 29 and days of care provided 2,073

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	239,009	5,417	12,694	257,120		257,120	(9,457)	247,663			1
2	Food Purchase		179,334		179,334		179,334	(31,779)	147,555			2
3	Housekeeping	184,852	29,843	1,790	216,485		216,485	(23,246)	193,239			3
4	Laundry	60,088	15,746	1,488	77,322		77,322		77,322			4
5	Heat and Other Utilities			96,192	96,192		96,192		96,192			5
6	Maintenance	201,145	22,600	32,854	256,599		256,599	(141,516)	115,083			6
7	Other (specify):*											7
8	**TOTAL General Services**	685,094	252,940	145,018	1,083,052		1,083,052	(205,998)	877,054			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,124,512	163,748	131,023	2,419,283		2,419,283	(36,776)	2,382,507			10
10a	Therapy	53,318	1,465	164,792	219,575		219,575		219,575			10a
11	Activities	126,926	6,159	618	133,703		133,703	(36,031)	97,672			11
12	Social Services	64,548	422	1,007	65,977		65,977		65,977			12
13	Nurse Aide Training	13,897	892	1,300	16,089		16,089		16,089			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,383,201	172,686	298,740	2,854,627		2,854,627	(72,807)	2,781,820			16
	C. General Administration											
17	Administrative	58,108			58,108		58,108	(16,543)	41,565			17
18	Directors Fees											18
19	Professional Services			26,468	26,468		26,468		26,468			19
20	Dues, Fees, Subscriptions & Promotions			22,060	22,060		22,060	(750)	21,310			20
21	Clerical & General Office Expenses	174,062	9,874	42,823	226,759		226,759	(71,148)	155,611			21
22	Employee Benefits & Payroll Taxes			683,515	683,515		683,515	(52,986)	630,529			22
23	Inservice Training & Education			6,125	6,125		6,125		6,125			23
24	Travel and Seminar			13,786	13,786		13,786		13,786			24
25	Other Admin. Staff Transportation			5,041	5,041		5,041		5,041			25
26	Insurance-Prop.Liab.Malpractice			22,083	22,083		22,083		22,083			26
27	Other (specify):*											27
28	**TOTAL General Administration**	232,170	9,874	821,901	1,063,945		1,063,945	(141,427)	922,518			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,300,465	435,500	1,265,659	5,001,624		5,001,624	(420,232)	4,581,392			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Snyder Village #0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			179,224	179,224		179,224	3,777	183,001			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,826	162,826		162,826	(70,064)	92,762			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,120	1,120		1,120		1,120			35
36	Other (specify):*											36
37	**TOTAL Ownership**			343,170	343,170		343,170	(66,287)	276,883			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,682	4,306	74,988		74,988		74,988			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,646	57,646		57,646		57,646			42
43	Other (specify):* Nonallowable costs			19,614	19,614		19,614	(19,614)				43
44	**TOTAL Special Cost Centers**		70,682	81,566	152,248		152,248	(19,614)	132,634			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,300,465	506,182	1,690,395	5,497,042		5,497,042	(506,133)	4,990,909			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(25,184)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,777	30		9
10	Interest and Other Investment Income	(70,064)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,847)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,194)	43		28
29	Other-Attach Schedule See Schedule 5A	(32,585)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (137,097)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(369,036)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (369,036)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (506,133)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Snyder Village

ID# 0033647

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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41				41
42				42
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44				44
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64				64
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66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Snyder Village	Metamora	Retirement
				Retirement		Community
See attached Schedule 6A				Community		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary Expenses	$ 9,457	Snyder Village Retirement Community	0.00%	$	$ (9,457)	1
2	V	2	Food	6,595	Snyder Village Retirement Community	0.00%		(6,595)	2
3	V	3	Housekeeping Expenses	20,328	Snyder Village Retirement Community	0.00%		(20,328)	3
4	V	6	Maintenance Expenses	141,516	Snyder Village Retirement Community	0.00%		(141,516)	4
5	V	10	Nursing Expenses	21,023	Snyder Village Retirement Community	0.00%		(21,023)	5
6	V	11	Activities Expenses	36,031	Snyder Village Retirement Community	0.00%		(36,031)	6
7	V	17	Administrator	16,543	Snyder Village Retirement Community	0.00%		(16,543)	7
8	V	21	Other Administrative Expenses	64,557	Snyder Village Retirement Community	0.00%		(64,557)	8
9	V	22	Employee Benefits	52,986	Snyder Village Retirement Community	0.00%		(52,986)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 369,036			$	$ * (369,036)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Commerce Bank		x	Building	$77,134.00	08/01/87	$ 1,750,000	$ 893,470	08/01/12	0.0611	$ 74,547	1
2	CDAP Village Metamor		x	Building	$14,648.00	08/01/87	200,000	41,150	07/01/04	0.0300	1,481	2
3	Commerce Bank		x	Facility Expansion	$6,979.00	09/01/93	665,000	122,545	09/01/10	0.0700	9,155	3
4	CDAP Village Metamor		x	Building	$3,029.00	02/02/97	50,000	32,382	01/01/09	0.0300	1,022	4
5	Commerce Bank		x	Construction	$38,905.00	04/01/94	1,035,000	785,977	04/01/11	0.0568	64,822	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$140,695.00		$ 3,700,000	$ 1,875,524			$ 151,027	9
	B. Non-Facility Related*											
10	From Schedule 9A						548,000	433,052			11,799	10
11								Interest Income Offset			(70,064)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 548,000	$ 433,052			$ (58,265)	14
15	TOTALS (line 9+line14)						$ 4,248,000	$ 2,308,576			$ 92,762	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village **#** 0033647 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999	N/A	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,870 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Snyder Village Retirement Community Apartments - 41 Apartments at 38,793 Square Feet
Snyder Village Retirement Community Cottages - 118 Cottages at 283,200 Square Feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	155,422	1987	$ 43,000	1
2					2
3	TOTALS	155,422		$ 43,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		1998	1988	$ 1,929,231	$ 42,872	45	$ 42,872	$	$ 535,899	4
5			1992	1992	127,495	2,833	45	2,833		24,318	5
6			1992	1992	33,830	1,353	25	1,353		11,051	6
7	18		1994	1994	600,872	13,353	45	13,353		91,244	7
8	26		1994	1994	1,256,597	27,924	45	27,924		169,872	8
	Improvement Type**										
9	Fire Control System			1989	5,152	258	20	258		2,898	9
10	Century Tub			1989	7,694		10			7,694	10
11	Asphalt			1990	1,820	91	20	91		956	11
12	Alzheimer's courtyard			1990	3,644	213	10	213		3,644	12
13	Heat Exchange			1990	1,650	28	10	27	(1)	1,650	13
14	Tub			1991	1,465	147	10	147		1,417	14
15	Door Locks			1991	1,400	70	20	70		636	15
16	Door Locks			1992	1,200	60	20	60		525	16
17	Patio			1992	1,219	122	10	122		1,046	17
18	Entrance Light			1993	619	62	10	62		470	18
19	Land Improvement			1994	25,546	1,277	20	1,277		7,770	19
20	Services Windows			1995	201,662	4,481	45	4,481		26,141	20
21	Landscaping			1995	13,848	692	20	692		4,154	21
22	Canopy			1995	1,102	55	20	55		280	22
23	Electrical Maintenance			1995	595	40	15	40		212	23
24	Door Locks			1995	505	34	15	34		183	24
25	Front Canopy			1996	44,945	999	45	999		4,328	25
26	Tower			1996	7,360	368	20	368		1,717	26
27	Door Open			1996	3,344	334	10	334		1,449	27
28	Landscaping			1997	1,500	75	20	75		263	28
29	Front Door Wiring			1997	1,396	70	20	70		268	29
30	Kelly Glass			1998	3,527	176	20	176		529	30
31	MTCO Phone System			1998	18,914	757	25	757		1,829	31
32	Carpet			1998	15,719	1,572	10	1,572		3,406	32
33	Heater			1999	1,784	178	10	178		312	33
34	Washer			1999	8,102	810	10	810		1,215	34
35	Security Camera			1999	2,510	167	15	167		334	35
36	TOTAL (lines 4 thru 35)				$ 4,326,247	$ 101,471		$ 101,470	$ (1)	$ 907,710	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Motion Detector			1999	790		10	79	79	158	9
10	Generator			1999	649		10	65	65	130	10
11	Shelving			1999	673		10	67	67	134	11
12	Blacktop			2000	21,736	91	20	1,087	996	1,087	12
13	Sunroom			2000	86,410	1,280	45	1,920	640	1,920	13
14	Generator			2000	36,206	1,659	20	1,810	151	1,810	14
15	Time Clock			2000	7,789	1,298	5	1,558	260	1,558	15
16	Motion Detector			2000	5,716	381	10	572	191	572	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 159,969	$ 4,709		$ 7,158	$ 2,449	$ 7,369	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 379,149	$ 53,126	$ 53,126	$	Various	$ 227,398	37
38	Current Year Purchases	16,947	2,482	3,662	1,180	Various	3,662	38
39	Fully Depreciated Assets	271,352				Various	271,352	39
40								40
41	TOTALS	$ 667,448	$ 55,608	$ 56,788	$ 1,180		$ 502,412	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Care	1985 Ford Van	1991	$ 3,130	$	$	$	3	$ 3,130	42
43	Resident Transportation	1994 Van	1994	47,025	4,703	4,703		10	29,390	43
44	Resident Transportation	1996 Van	1996	51,573	5,157	5,157		10	21,059	44
45	See Schedule 13A			38,626	7,725	7,725			18,252	45
46	TOTALS			$ 140,354	$ 17,585	$ 17,585	$		$ 71,831	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,337,018	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 179,373	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 183,001	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,628	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,489,322	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Work in Progress -	$ 465,654	58
59	Administrative Offices		59
60			60
61		$ 465,654	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,120 Description: Postage Machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			892		892
3	Classroom Wages	(a)		6,982		6,982
4	Clinical Wages	(b)		3,513		3,513
5	In-House Trainer Wages	(c)		3,402		3,402
6	Transportation					
7	Contractual Payments			600		600
8	Nurse Aide Competency Tests			700		700
9	TOTALS		$	$ 16,089	$	$ 16,089
10	SUM OF line 9, col. 1 and 2	(e)	$ 16,089			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 3,302

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	15
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	22

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	1,218	$	53,719	$	1,218	$ 53,719	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		72		4,235		72	4,235	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10a, C2, 3	hrs		2,087		93,334	1,465	2,087	94,799	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39, C2	# of prescrpts					70,682		70,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Lab / Xray	L39, C3					4,306			4,306	13
14	TOTAL			$	3,377	$	155,594	$ 72,147	3,377	$ 227,741	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 838,606	$ 838,606	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	475,050	475,050	3
4	Supply Inventory (priced at Cost)	27,750	27,750	4
5	Short-Term Investments	16,777	16,777	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,369	5,369	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,363,552	$ 1,363,552	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	449,514	449,514	12
13	Land	43,000	43,000	13
14	Buildings, at Historical Cost	4,485,414	4,486,216	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	805,742	807,802	16
17	Accumulated Depreciation (book methods)	(1,485,334)	(1,489,322)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): WIP	465,654	465,654	22
23	Other(specify): Resident in Need Endowment	106,726	106,726	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,870,716	$ 4,869,590	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,234,268	$ 6,233,142	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 85,078	$ 85,078	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	218,527	218,527	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,044	35,044	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedules 17A	212,282	212,282	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 550,931	$ 550,931	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,308,576	2,308,576	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,308,576	$ 2,308,576	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,859,507	$ 2,859,507	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,374,761	$ 3,373,635	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,234,268	$ 6,233,142	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,039,685	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,039,685	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	335,076	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 335,076	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,374,761	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,719,036	1
2	Discounts and Allowances for all Levels	(326,714)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,392,322	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	349,095	6
7	Oxygen	76,125	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 425,220	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,184	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,635	13
14	Non-Patient Meals	25,184	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	139,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,400	20
21	Other Medical Services	184,560	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 362,549	23
	D. Non-Operating Revenue		
24	Contributions	135,374	24
25	Interest and Other Investment Income***	70,064	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 205,438	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	446,589	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 446,589	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,832,118	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,083,052	31
32	Health Care	2,854,627	32
33	General Administration	1,063,945	33
	B. Capital Expense		
34	Ownership	343,170	34
	C. Ancillary Expense		
35	Special Cost Centers	94,602	35
36	Provider Participation Fee	57,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,497,042	40
41	**Income before Income Taxes (line 30 minus line 40)****	335,076	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 335,076	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**
This entity is Tax Exempt

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,847	2,117	$ 45,759	$ 21.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,702	31,063	555,525	17.88	3
4	Licensed Practical Nurses	13,115	14,921	213,237	14.29	4
5	Nurse Aides & Orderlies	100,710	110,666	1,116,176	10.09	5
6	Nurse Aide Trainees	947	1,041	10,495	10.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,022	5,383	53,318	9.90	8
9	Activity Director					9
10	Activity Assistants	12,438	13,570	108,521	8.00	10
11	Social Service Workers	6,097	6,652	64,548	9.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,763	30,189	239,009	7.92	15
16	Dishwashers					16
17	Maintenance Workers	18,436	19,813	201,145	10.15	17
18	Housekeepers	21,956	23,452	184,852	7.88	18
19	Laundry	7,207	8,092	60,088	7.43	19
20	Administrator	1,882	2,137	58,108	27.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,860	2,062	27,736	13.45	23
24	Clerical	12,023	12,822	146,326	11.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify) See 20A	15,258	16,402	215,622	13.15	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	275,263	300,382	$ 3,300,465 *	$ 10.99	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	191	$ 6,689	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	640	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	L10, C3	39
40	Physical Therapy Consultant	167	6,998	L10a, C3	40
41	Occupational Therapy Consultant	151	6,506	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	480	L11, C3	44
45	Social Service Consultant	21	840	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	542	$ 23,053		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	297	$ 8,896	L10, C3	50
51	Licensed Practical Nurses	346	10,386	L10, C3	51
52	Nurse Aides	6,358	108,089	L10, C3	52
53	TOTAL (lines 50 - 52)	7,001	$ 127,371		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keith Swartzentruber	Administrator	0.00%	$ 58,108
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,108

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinold-Banwart Ltd	Accounting	$ 13,523
Altschuler Melvoin & Glasser LLP	Accounting	7,000
American Express Tax & Bus Svc	Accounting	5,145
Davis & Campbell LLC	Legal	300
Ronald B Schertz	Legal	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 26,468

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,746
Unemployment Compensation Insurance	
FICA Taxes	191,672
Employee Health Insurance	218,673
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis B Immunization/Employee Physicals	1,760
Tuition Assistance	252
Employee Pension Plan	95,817
Sick, Jury Duty & Funeral Pay	14,406
Life Insurance	5,324
Employee Relations	22,879
TOTAL (agree to Schedule V, line 22, col.8)	$ 630,529

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,136
Health Care Worker Background Check	
(Indicate # of checks performed 113)	1,356
Life Services Network	3,999
Miscellaneous Dues	559
The Herald subscription	70
RN license renewal	40
CLIA license	150
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,310

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,983
See attached	
Seminar Expense	9,803
See attached	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,786

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Snyder Village # 0033647 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Snyder Village # 0033647 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $ 3,999**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **4.49 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,563** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **57,646**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
Therapy is reflected in therapy costs

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **25,184**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate Records are Maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.